

**Bariatric Surgery Precertification Request Form
BlueCross BlueShield of Tennessee**

*The BCBST Medical Policy for Bariatric Surgery for Morbid Obesity can be found at
http://www.bcbst.com/MPManual/Bariatric_Surgery_for_Morbid_Obesity.htm*

*Does not apply to the State of TN Member Contract.
Does not apply to TRH Health Plans, please refer to the TRH Health Plans' Member EOC.
Does not apply to SymbionARC Management Services, Inc. Welfare Benefit Plan.
Does not apply to CoverTN, AccessTN and CoverKids.*

**NOT ALL CONTRACTS INCLUDE OBESITY SURGERY BENEFITS. PLEASE CALL 1-800-225-8698
TO SPEAK WITH A BARIATRIC CASE MANAGEMENT TO VERIFY REQUIREMENTS FOR EACH
MEMBER. PLEASE FAX THIS COMPLETED FORM TO: 1-888-328-0394 OR MAIL TO:**

*BlueCross BlueShield of Tennessee
Utilization Management
1 Cameron Hill Circle, Suite 0017
Chattanooga, TN 37402-0017*

**THIS IS A TWO PART FORM. PART I MUST BE COMPLETED BY THE BARIATRIC SURGEON. PART
2 MUST BE COMPLETED BY THE ATTENDING PHYSICIAN (OTHER THAN THE BARIATRIC
SURGEON OR HIS/HER ASSOCIATES). FAILURE TO COMPLETE ALL ITEMS MAY RESULT IN
DELAY OR DENIAL OF PRECERTIFICATION AUTHORIZATION.**

PART 1 (MUST BE COMPLETED BY REQUESTING BARIATRIC SURGEON):

Date: _____

Member Name: _____ Member BCBS ID#: _____

Member Telephone: (home) _____ (work) _____ (cell) _____

To your knowledge, has this member previously had a Bariatric surgery? If yes, please provide details including type of procedure, date of procedure, and other pertinent information: _____

Procedure(s) requested, including ICD-9 procedure code(s): _____

Facility where surgery will be performed: _____ Tentative date of surgery: _____

Type of admission requested: (one-day, 23 hour one-day observation, inpatient): _____

Is the individual 18 years old or older? _____

PSYCHOLOGIST/PSYCHIATRIST INFORMATION MUST BE ATTACHED AND INCLUDE THE FOLLOWING:

This psychologist/psychiatrist evaluation must be submitted on the psychologist/psychiatrist's letterhead and signed by the psychologist/psychiatrist and must include **all** of the following, including each test result:

- Documentation of individual's willingness to comply with both the pre and postoperative treatment plans.
- Interview/evaluation results.
- Minnesota Multiphasic Personality Inventory
- The Eating Disorder Inventory or the Eating Attitudes Test (EAT-26).

NOTE: If the above (Interview/evaluation, Minnesota Multiphasic Personality Inventory, The Eating Disorder Inventory or the Eating Attitudes Test (EAT-26) or the Psychological evaluation) provides a suggestion of cognitive slippage or psychosis, a projective test (e.g., thematic apperception test (TAT) or the Rorschach test) is required.

Bariatric surgeon's name, address, telephone, and BCBS of TN provider number: _____

Bariatric surgeon's signature: _____ **Date:** _____

I have reviewed this patient's clinical information and recommend that they have the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and that clinical records substantiating this documentation are available for review, if requested.

PART 2 (MUST BE COMPLETED BY ATTENDING PHYSICIAN, SOMEONE OTHER THAN BARIATRIC SURGEON OR HIS/HER ASSOCIATES):

Date: _____

Member Name: _____ **Member BCBS ID#:** _____

Member Telephone: (home) _____ (work) _____ (cell) _____

To your knowledge, has this member previously had a Bariatric surgery? If yes, please provide details including type of procedure, date of procedure, and other pertinent information: _____

Conservative attempts at weight loss made within the last two (2) years (example - low calorie diet, daily exercise, Weight Watchers, Medically supervised weight loss):

Date(s): _____ Conservative attempt: _____

Date(s): _____ Conservative attempt: _____

Date(s): _____ Conservative attempt: _____

(If additional space is needed, please include a separate sheet).

Has the member achieved 10% weight loss? _____

Start date and weight _____ **End date and weight** _____

Weights for the last five (5) years. At least one data set is required per year.

Date: _____ Height: _____ Weight: _____

Date: _____ Height: _____ Weight: _____

Date: _____ Height: _____ Weight: _____

Date: _____ Height: _____ Weight: _____

Date: _____ Height: _____ Weight: _____

(If additional space is needed, please include a separate sheet).

ALL of member's Past Medical history and current Diagnosis. Per medical policy- BMI 35 to 39.9 attending must submit appropriate documentation of obesity related co morbidities which would include CAD, Type 2 Diabetes, Obstructive Sleep Apnea, HTN.

- 1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

(If additional space is needed, please include a separate sheet).

Please list current pertinent medications:

Please provide all test results with dates associated with diagnosis above (HDL, LDL, Blood Pressure, Blood Glucose)

Attending physician's name, address, telephone, and BCBS of TN provider number: _____

Attending physician's signature: _____ **Date:** _____

I have reviewed this patient's clinical information and recommend that they have the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and that clinical records substantiating this documentation are available for review, if requested.

Note: BlueCross BlueShield of Tennessee reserves the right to request additional information.